MAINE DEPARTMENT OF HEALTH & HUMAN SERVICES
DIVISION OF LICENSING AND REGULATORY SERVICES

APPLICATION FOR RENEWAL OF LICENSURE OF A HOSPICE PROGRAM

FOR PERIOD:_____ TO:_____

1. **NAME OF AGENCY:**_____

   DOING BUSINESS AS:_____

   LOCATED AT:_____
   (Street or Road) (City or Town) (Zip Code)

   _____
   (County) (Telephone Number)

   E-Mail Address: _____

2. **DIRECTIONS FOR REACHING AGENCY** (Please be specific; Draw may, if possible).

3. **MAILING ADDRESS, IF DIFFERENT:**

   _____
   (Street or Road) (City or Town) (Zip Code) (County)

4. **OWNERSHIP:** (Name & Address of Owner(s)--Individual, Partners, Corporation Name)

   _____
   IDENTIFICATION NUMBER: _____
   (Owner's Social Security No. or IRS Identification No.)

INSTRUCTIONS

A. If sole proprietor, list name of owner (See A. below).
B. For business entities with business partnerships, the full name and address of each partner (See B. on Page 2).
C. If proprietary corporation, the name, address and titles of each person, firm or corporation, having (directly or indirectly) an ownership interest of 5% or more in the agency (See C. on Page 2).
D. For not-for-profit organizations, the name and address of the President of the Board of Directors or appropriate municipal government representative (See D. on Page 2).

TYPE OF ENTITY

A. ____ SOLE PROPRIETORSHIP
B. ____ PARTNERSHIP
C. ____ CORPORATION
D. ____ NOT-FOR-PROFIT
E. ____ OTHER (Specify)
_____

A. **IF SOLE PROPRIETORSHIP**, list name of Owner: _____

B. **IF PARTNERSHIP**, list names and addresses of partners or organizations having direct or indirect ownership interests, separately or in combination, amounting to an ownership interest of 5% or more in the disclosing entity. Indirect ownership interest is ownership interest in an entity that has an ownership in any entity higher in a pyramid than the disclosing entity.

NAME ADDRESS

_____

_____

_____

_____

C. **IF THE DISCLOSING ENTITY IS A CORPORATION**, list names, addresses and titles of the Officers and Directors.

1. OFFICER'S NAMES TITLE ADDRESS

_____
_____
_____
_____

2. DIRECTOR'S NAMES TITLE ADDRESS

_____
_____
_____
_____

D. **IF THE DISCLOSING ENTITY IS NOT-FOR-PROFIT ORGANIZATION**, list name and address of President of the Board of Directors or the appropriate Municipal Government Representative.

NAME ADDRESS

_____
_____

5. **IF THE BUILDING(S) USED BY A HOSPICE PROVIDER IS/ARE LEASED**, a copy of each lease shall be attached to this application.

6. **NAME AND TITLE OF PERSON IN CHARGE:** _____

_____

Home Address Home Telephone No. Office Telephone No.

7. **THE HOSPICE PROGRAM**

1. Has been open since: _____(Date)

2. Plans to open: _____(Date)

8. **LOCATION OF ALL FACILITIES (SUB-UNITS) UTILIZED BY THE HOSPICE PROGRAM PROVIDER.**

Address Telephone No. Name of Owner of Building

(a) _____

_____

(b) _____

_____

(c) _____

_____

(d) _____

_____

9. **PLEASE ATTACH A <u>LETTER</u> FROM APPROPRIATE MUNICIPAL OFFICIAL(S) THAT DEMONSTRATES COMPLIANCE WITH ALL <u>LOCAL ORDINANCES</u> RELATIVE TO Z<u>ONING AND BUILDING CODE REGULATIONS IF YOU HAVE MOVED SINCE LAST RENEWAL</u>.**

10. **PLEASE CHECK EACH TYPE OF HOSPICE PROGRAM PROVIDER SERVICE PROVIDED AND LIST DATE SERVICE WAS STARTED.**

	<u>Check Here</u>	<u>Date</u>
a. Nursing Services	_____	_____
b. Medical Social Services	_____	_____
c. Physician Services	_____	_____
d. Counseling Services	_____	_____
e. Volunteer Services	_____	_____
f. Physical Therapy Services	_____	_____
g. Occupational Therapy Services	_____	_____
h. Speech/Language Therapy Services	_____	_____
i. Home Health Aides & Homemaker Services	_____	_____
j. Other Services Provided	_____	_____

11. **IS THIS HOSPICE PROGRAM ACCREDITED? _____ JCAHO _____ CHAPS**

12. **TOTAL NUMBER OF FULL-TIME EQUIVALENT STAFF EMPLOYED BY THE AGENCY _____**

(All employees of the Hospice Program Provider, including administrative, business, clerical and direct service providers, must be included in the calculation of this figure. A full-time equivalent employee is one or more individuals who is/are employed on the basis of at least 37 1/2 hours per week for the home health agency. Both individuals directly employed and those contracted by the agency shall be counted in the calculation of the agency's full-time equivalency figure).

13. **PLEASE ATTACH A <u>LETTER</u> FROM THE OFFICE OF HEALTH PLANNING AND DEVELOPMENT STATING WHETHER OR NOT A CERTIFICATE OF NEED IS REQUIRED FOR YOUR AGENCY TO PROVIDE HOSPICE SERVICES**.

14. **FEES**. The initial application fee is $200.00. Thereafter, an annual fee of $200.00 will be assessed.

Make a check or money order payable to: <u>Treasurer, State of Maine</u>**,** and mail it to the

The Division of Licensing and Regulatory Services
Medical Facilities Unit
41 Anthony Avenue, #11 SHS
Augusta, Maine 04333-0011.

The applicant certifies that all information contained in this application is true and correct to the best of his/her knowledge.

The Department of Health & Human Services reserves the right to request/review any additional information that will be necessary to determine the suitability of the applicant for licensure.

I, _____, BEING DULY AUTHORIZED TO ASSUME RESPONSIBILITY FOR THE CONDUCT OF THE AGENCY HEREIN DESCRIBED, DO HEREBY APPLY FOR A LICENSE TO OPERATE THE AGENCY AND DO AGREE TO ASSUME RESPONSIBILITY THAT THE AGENCY WILL COMPLY WITH ALL THE CURRENT REGULATIONS OF THE DEPARTMENT OF HEALTH & HUMAN SERVICES, AS AUTHORIZED BY TITLE 22, M.R.S.A. CHAPTER 1681, SECTIONS 8621 - 8631.

_____ _____
(Date) Signature of Program Administrator

_____
Title

If space provided to completely respond to application is inadequate, please attach necessary information.

FOR OFFICE USE ONLY

FEE_____
Checked by: _____
Check Number _____